SUBCOMMITTEE NO. 3 Agenda
Health, Human Services, Labor & Veteran's Affairs

Chair, Senator Elaine K. Alquist

Senator Alex Padilla
Senator Mark Wyland

April 7, 2008

10:30 AM

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item	Department
4280	**Managed Risk Medical Insurance Board—*Selected Issues***
4260	**Department of Health Care Services—*Selected Issues***

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Thank you.

Managed Risk Medical Insurance Board (MRMIB)

A. OVERALL BACKGROUND (Pages 2 through 5)

Purpose and Description of Department. The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health care coverage through private health plans to certain groups without health insurance. **The MRMIB administers the: (1)** Healthy Families Program; **(2)** Access for Infants and Mothers (AIM) Program; and **(3)** Major Risk Medical Insurance Program (MRMIP).

Summary of Funding. The budget proposes total expenditures of almost $1.4 billion ($432.3 million General Fund, $846.2 million Federal Trust Fund and $115.1 million in other funds) for all programs administered by the Managed Risk Medical Insurance Board. A summary of projected program expenditures is shown below, ***prior*** to the Governor's proposed reductions. I

Summary of Expenditures (dollars in thousands)	**2007-08**	**2008-09**	**$ Change**	**% Change**
Program Source				
Major Risk Medical Insurance Program (including state support)	$40,089	$35,999	-$4,090	1.0
Access for Infants & Mother (with state support)	$135,563	$154,692	$19,129	14.1
Healthy Families Program (with state support)	$1,099,469	$1,200,055	$100,586	9.1
County Health Initiative Program	$2,777	$2,874	$97	3.5
Totals Expenditures	**$1,277,898**	**$1,393,620**	**$115,722**	**9.1**
General Fund	$396,040	$432,338	$36,298	9.2
Federal Funds	$770,423	$846,213	$75,790	9.8
Other Funds	$111,435	$115,069	$3,634	3.3
Total Funds	**$1,277,898**	**$1,393,620**	**$115,722**	**9.0**

Governor's Proposed Reductions for Managed Risk Medical Insurance Board. The Governor declared a fiscal emergency on January 10th, utilizing the authority provided within the State Constitution as provided for under Proposition 58 of 2004. Under this authority, the Governor can call the Legislature into Special Session to deal with substantial revenue declines or expenditure increases, and to address the fiscal emergency. Other than utilizing remaining bond financing, the Governor has generally proposed a 10 percent across-the-board reduction approach to the fiscal emergency.

With respect to the Managed Risk Medical Insurance Board, the Governor has proposed a reduction of $121.7 million ($43.2 million General Fund *and* $78.5 million federal funds) as shown in the table below. It should be noted that the savings level shown below assumed a July 1, 2008 implementation date.

Governor's Proposed Reductions to Healthy Families Program

Healthy Families Program	Governor's Proposed 2008-09 Reduction (General Fund)	Governor's Proposed 2008-09 Reduction (Total Funds)
Reduce rates paid to participating health plans by 5%	-$22,400,000	-$63,100,000
Benefit limit for dental coverage ($1,000 annually)	-$6,300,000	-$17,700,000
Increase premiums families pay for coverage	-$11,100,000	-$31,300,000
Increase co-payments for certain services	-$3,400,000	-9,600,000
Total Reduction to Program	**-$43,200,000**	**-$121,700,000**

Legislature's Special Session Actions. After numerous hearings convened by both the Senate and Assembly, the Legislature took action to reduce the current-year shortfall of $3.3 billion and converted it into a little over $1 billion in General Fund reserve. In addition, the actions of the Legislature provided $8.6 billion in cash management solutions to enable the state to maintain its ability to pay its bills.

The resulting projected budget year deficiency was reduced by $7 billion, leaving an estimated shortfall of almost $8 billion at this time.

No actions were taken by the Legislature to reduce the Healthy Families Program.

Overall Background—Description of the Healthy Families Program. The Healthy Families Program (HFP) provides health, dental and vision coverage through managed care arrangements to children (up to age 19) in families with incomes up to 250 percent of the federal poverty level, who are *not* eligible for Medi-Cal but meet citizenship or immigration requirements. The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis.

In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into the Healthy Families Program and can remain under the HFP until at least the age of two. If these AIM to HFP two-year olds are in families that exceed the 250 percent federal income level, then they are no longer eligible to remain in the HFP.

There are also two "bridge" programs that enable children to transition from Medi-Cal to the HFP, and from the HFP to Medi-Cal. This is done in order to help ensure continued coverage for children who may be going back and forth between the two programs due to family income changes, or a change in their age. It should be noted that with the enactment of Senate Bill 437 (Escutia), Statutes of 2006, the "bridge" programs will phase-out and presumptive eligibility processes will be implemented.

Background Summary of Eligibility for the Healthy Families Program (HFP)

Type of Enrollee in the HFP	Income Level Based on Federal Poverty	Comments
Infants up to the age of two years who are born to women enrolled in Access for Infants & Mothers.	200 % to 300 %	• Income from 200% to 250%, covered through age 18. • Income is above 250 %, they are covered up to age 2.
Children ages one through 5 years	133 % to 250 %	Healthy Families Program covers from 133 percent and above because children below this are eligible for Medi-Cal.
Children ages 6 through 18 years	100 % to 250 %	Healthy Families Program covers children in families above 100 %. Families with two children may be "split" between programs due to age.
Some children enrolled in County "Healthy Kids" programs. These include (1) children without residency documentation; and (2) children from 250 percent to 300 percent of poverty.	Not eligible for Healthy Families Program, including 250 percent to 300 percent	State provides federal S-CHIP funds to county projects as approved by the *MRMIB.* Counties provide the match for the federal funds.

Background—HFP Benefit Package. The HFP benefit package is modeled after that offered to state employees, including health, dental and vision. The enabling federal legislation—the State's Children's Health Insurance Program (S-CHIP)—required states to use this "benchmark" approach. These benefits are provided through managed care arrangements. The HFP directly contracts with participating health, dental and vision care plans. Participation from these plans varies across the state but consumer choice has *historically* always been available.

In addition to these HFP benefits, enrolled children can also access the California Children's Services (CCS) Program if they have a CCS-eligible medical condition. An HFP enrolled child is also eligible to receive *supplemental* mental health services provided through County Mental Health Plans. These additional services are provided in accordance with state statute that created California's Healthy Families Program (i.e., California's S-CHIP). These services are also available to children enrolled in Medi-Cal.

Background—HFP Premiums. Families pay a monthly premium and copayments, as applicable. The amount paid varies according to a family's income and the health plan selected. Families below 200 percent of poverty pay premiums ranging from $4 to $9 per child per month, up to a family maximum of $27 per month. Families that select a health plan designated as a "community provider plan" receive a $3 discount per child on their monthly premiums. Families with incomes between 200 percent and 250 percent of poverty pay $12 to $15 per child per month. The family maximum per month is $45 for these families.

Summary of Budget Year Funding and Enrollment for the HFP. A total of almost $1.1 billion ($387.8 million General Fund, $676.2 million Federal Title XXI Funds, $904,000 Proposition 99 Funds, and $7.4 million in reimbursements) is proposed for the HFP, excluding state administration. This reflects a reduction of almost $37 million ($10.8 million General Fund), or a 3.3 percent reduction as compared with the Budget Act of 2007. Most of this decrease is attributable to the Governor's proposed reductions, as well as adjustments to projected caseload.

The HFP is funded at a *65 percent federal match* through a federal allotment (i.e., this is not a federal entitlement program).

The budget assumes a total enrollment of 954,252 children as of June 30, 2008, an increase of 45,340 children over the revised current year enrollment level, or a growth rate of about 5 percent.

Total HFP enrollment of 954,252 children is summarized by population segment below:

- Children in families up to 200 percent of poverty 687,361 children
- Children in families between 201 to 250 percent of poverty 211,034 children
- Children in families who are legal immigrants 17,478 children
- Access for Infants and Mothers (AIM)-Linked Infants 16,798 children
- New children due to changes in Certified Application Assistance 4,574 children
- New children due to improvements in the enrollment process 5,333 children
- New children due to implementation of SB 437, Statutes of 2006 11,674 children

(Discussion items begin on next page.)

1. Governor Proposes Increase in Healthy Families Subscriber Premiums

Issue. The Governor proposes to increase the monthly premium amounts paid by families for their children to receive health care services under the Healthy Families Program. The MRMIB uses these monthly subscriber payments to offset overall program expenditures which then reduces the need for General Fund support. The HFP is funded at a *65 percent federal match* through a federal allotment (i.e., this is not a federal entitlement program).

The table below displays the current premium payment and the Governor's proposed increase. Specifically, Subscribers from 151 to 200 percent would experience a *77 percent increase* ($7 dollars more per month per child). Subscribers from 201 to 250 percent would experience a *27 percent increase* ($4 dollars more per month per child).

A total reduction of $31.3 million ($11.1 million General Fund and $20.2 million federal S-CHIP funds) is assumed from this proposal with an effective date of July 1, 2008. This action would require state statutory change, emergency regulation authority and a state plan amendment (i.e., a change to the state's plan filed with the federal government.

Governor's Healthy Families Program—Proposed Premium Increases

HFP Subscriber Family Income %	Existing Monthly Premium Payment	Governor's Premium Payment	Increase Per Month	Annualized Increase (12 months)
100 to 150 percent	$7 per child Maximum per family of $14	No change	--	--
151 to 200 percent	$9 per child Maximum per family of $27	$16 per child Maximum per family of $48	$7 child $21 family	$84 child $252 family
200 to 250 percent	$15 per child Maximum per family of $45	$19 per child Maximum per family of $57	$4 child $12 family	$48 child $144 family

The MRMIB states that *no* federal approval is needed for this proposal because California would still meet federal cost-sharing requirements of not exceeding 5 percent of a family's income for program expenditures (such as through premium payments and copayments for services).

The MRMIB notes that families with incomes from 151 to 200 percent of poverty have not had their premiums increased since inception of the program in 1998. Families with incomes from 200 to 250 percent of poverty had their premiums increased from $9 per child to $15 ($6 dollar increase) and $27 per family to $45 ($18 dollar increase) as of July 1, 2005.

It should be noted that the MRMIB savings level does not recognize any reduction in caseload occurring due to their proposed increase in premiums.

Background on HFP Premiums and Premium Discount Options. HFP premiums are in state statute and *must be paid* by families to maintain their child's enrollment in the program. Subscribers with incomes over 200 percent of poverty had their premiums increased as of July 1, 2005 (from $9 to the present $15 per child). No other Subscriber categories have had their premiums increased since inception of the program back in 1998.

The HFP does offer subscribers "premium discount options" to offset some costs associated with premiums and co-payments. Discounts offered include (1) $3 per child per month discount for enrollment in a "community provider plan"; (2) subscriber paying 3 months in advance to get one month "free"; and (3) a 25 percent monthly discount for payment of premiums through electronic funds transfer or reoccurring credit card payment.

Subcommittee Staff Comment and Recommendation—Hold Open. The Governor's proposal would significantly increase premiums for two categories of Subscribers—children with family incomes from 151 to 200 percent and children with family incomes from 200 to 250 percent. Specifically, Subscribers from 151 to 200 percent would experience a *77 percent increase* ($7 dollars more per month). Subscribers from 201 to 250 percent would experience a *27 percent increase* ($4 dollars more per month).

The MRMIB anticipates increased use of the premium discount options. However, it is likely that some families would be unable to pay premiums given the increase and will disenroll or not enroll their children. The MRMIB has not accounted for any decrease in enrollment which is likely to occur under their proposal.

Families at these poverty income levels experience significant difficulties living in the California economy. One of the original intents of the enabling Healthy Families Program legislation is to ensure access to health, dental and vision care for low-income families. Significant increases in premiums clearly deter enrollment and access to services.

If the Legislature chooses to raise the HFP premiums above existing levels, consideration should be given to adjusting by a lower amount and to obtain information from the MRMIB regarding the relationship between premium increases and caseload decreases (children being disenrolled for lack of payment and families not enrolling children due to the premium level). More analysis needs to be done regarding this threshold question.

Further, the MRMIB notes that any changes to HFP premiums above existing levels will require a lead time of about 4 months to effectuate the change.

It is recommended to hold this issue open pending receipt of the May Revision.

Questions. The Subcommittee has requested the MRMIB to respond to the following questions:

1. MRMIB, Please provide a brief summary of the proposal.
2. MRMIB, How would increasing the premium families pay for their children in Healthy Families potentially affect HFP enrollment (caseload)?

2. Governor's Proposal to Increase Co-Payments for Services Under HFP

Issue. The Governor proposes to increase the co-payments of HFP subscribers from $5 to $7.50 for *non-preventive* services for children in families with incomes *over* 150 percent of poverty (i.e., from 151 to 250 percent). Co-payments are paid by parents when they take their child in for certain types of medical appointments and services.

A total reduction of $9.6 million ($3.4 million General Fund and $6.2 million federal S-CHP funds) is assumed from this action. This proposal requires a statutory change, emergency regulation authority, and a State Plan Amendment to implement. No federal approval is needed. This savings level assumes a July 1, 2008 implementation date; however the MRMIB notes that they would need about four months to implement this proposal if the Legislature adopts it.

Non-preventive services is a broad category and includes, but is not limited to, the following:

- Emergency room visits if not hospitalized;
- Doctor visits for other than well-child visits, inpatient services or chronic care treatment;
- Prescriptions;
- Eye Exams and Prescription glasses;
- Physical, speech, and occupational therapy; and
- Root canals, oral surgery, crowns, bridges, and dentures.

This proposal would increase co-payments by $2.50, or 50 percent more than paid now, for families over 150 percent of poverty. The MRMIB states this amount was selected due to the savings level it achieves.

It is assumed that an increase in co-payments will reduce utilization of services by families (their children), and thereby, reduce plan rates by about 1.25 percent.

Subcommittee Staff Comment and Recommendation—Hold Open. This proposal to increase co-payment proposal, coupled with the proposal to increase premiums, would still meet the federal cost-sharing requirement of not exceeding 5 percent of a family's income.

However, as noted in the table below, the Governor's proposals (co-payment and premium combined) would increase a family's cost significantly—42 percent and 28 percent respectfully.

Percent of Annual Family Income Spent on Healthy Families Enrollment

Income Level	Current Level	Proposed Level	Increase/Change
150 to 200 percent	1.9 percent	2.7 percent	42 percent increase
200 to 250 percent	1.8 percent	2.3 percent	28 percent increase

It should be noted that the Administration's savings level assumes a 1.25 percent reduction in medical treatment utilization due to the increase in the co-payment. Because of the co-payment increase, they anticipate that parents will take their children in for appointments and/or medical treatment less often due to the expense.

Another aspect of the co-payment proposal is that it would likely be cumbersome to administer because families would need to inform providers of their income level whereas this is not required at this time. When it comes to co-payments there is presently no stratification between the income levels.

Therefore, increasing the co-payments as proposed would be difficult for families and cumbersome to administer.

Questions.

1. MRMIB, Please provide a brief summary of the proposal and how it would be administered.
2. MRMIB, Please explain the anticipated drop in utilization of 1.25 percent.

3. Governor's Proposal to Limit Dental Coverage

Issue. The Governor proposes to institute an annual limit of $1,000 per child for dental coverage within the HFP for a total reduction of $17.7 million ($6.3 million General Fund and $11.4 million federal S-CHIP funds).

A July 1, 2008 implementation date is assumed. Implementation would require (1) state statutory change; (2) emergency regulation authority; (3) contracts to be re-negotiated with plans; and (4) a State Plan Amendment. The MRMIB states that it will take about 4 months to implement this proposal if adopted by the Legislature.

This proposal would limit the annual dental coverage offered to subscribers and would reduce plan costs (i.e., rates). As such, this proposal also interacts with the 5 percent rate reduction issue as discussed below (item 4 on this Agenda), as well as the Governor's proposal to increase co-payments.

According to the MRMIB and their contracted actuary, establishing this dental limit would result in a 12 percent savings in dental benefits over the current year.

The MRMIB contends that if the $1,000 cap is imposed, dental benefits will remain the same; however subscribers with multiple dental needs would likely need to spread services over more than one-year (i.e., in order to avoid the cap and pay out-of-pocket on the amount above the cap). T
he MRMIB's actuary estimates that 5 percent of the HFP subscribers would reach the $1,000 annual limit.

Background on Dental Coverage. Presently, the MRMIB contracts with 6 dental plans for the provision of dental care services to children enrolled in the HFP. These plans receive a capitated reimbursement from the HFP based on a defined benefit package and contract rate negotiations.

The HFP dental plan provides dental services which are very similar to those received by state employees (i.e., under CalPERS plans). The MRMIB does not provide orthodontia; this is done through the CA Children's Services (CCS) Program when it is medically necessary.

Subcommittee Staff Comment and Recommendation—Hold Open. This proposal needs to be viewed in the overall context of the other HFP reduction proposals. More clarification is also needed regarding the percentage of HFP enrolled children who would likely reach the cap.

Further, consideration should be given for providing preventive dental cleanings outside of any proposed cap. It is recommended to hold this issue open until receipt of the Governor's May Revision.

Questions. The Subcommittee has requested the MRMIB to respond to the following questions.

1. MRMIB, Please provide a brief summary of your proposal, including any needed statutory changes
2. MRMIB, Please explain how the existing dental benefits would remain the same if a 12 percent savings would be achieved through this proposal?
3. MRMIB, Please describe how the children are that would be most affected by this proposal (such as what type of dental needs are likely to go above the $1,000 cap).
4. MRMIB, Would preventive dental cleanings be included in the cap?

4. Governor's Proposal to Reduce Healthy Families Plan Rates by 5 Percent

Issue. The Governor proposes to reduce by 5 percent, for a total reduction of $63.1 million ($40.7 million federal S-CHIP), the rates paid to plans participating in the Healthy Families Program. A July 1, 2008 implementation is assumed. This proposed reduction would affect all plans (health, dental and vision).

Generally, the MRMIB negotiates contracts annually and is noted for operating an efficient program. MRMIB presently contracts with 23 health plans, 6 dental plans, and 3 vision plans to achieve statewide coverage.

Plan rates, including health, dental and vision, are normally negotiated between January and March and approved by the MRMIB Board in March of each year for the upcoming budget year. MRMIB negotiates with plans on a confidential basis.

This proposal requires: (1) a statutory change; (2) emergency regulation authority; (3) contracts to be re-negotiated with the plans; and (4) a State Plan Amendment which requires federal approval. This proposal interacts with the limit to dental coverage, and the proposal to increase copayments, below.

The MRMIB states that it will take about 4 months to implement this proposal if adopted by the Legislature.

Subcommittee Staff Comment and Recommendation—Hold Open. This issue needs to be viewed within the context of the other HFP proposals as well.

Though the MRMIB does not anticipate any benefit reductions resulting from the proposed rate reduction, this could be a consequence of the proposal since health plans would likely desire to curtail their costs based on a reduced capitation rate. There is also the potential for reduced access to services if a plan needs to limit its network due to the rate reduction.

Currently there are 7 counties with only one health plan available. If the 5 percent reduction occurs, and this plan decides not to contract with the HFP, MRMIB would have to find another plan. It is not fully clear on what may occur under this situation.

This proposal also interacts with the limit to dental coverage and the proposal to increase copayments.

It is recommended to hold this issue open pending the May Revision.

Questions. The Subcommittee has requested the MRMIB to respond to the following questions:

1. MRMIB, Please provide a brief summary of the proposal.

2. MRMIB, What is your perspective regarding the potential for a lack of statewide coverage for services, the potential for limiting networks and the potential for benefit limitations under this proposal?

Department of Health Care Services: Medi-Cal Program

A. OVERALL BACKGROUND

Purpose: The federal Medicaid Program (called Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance. Generally, California receives a 50 percent match from the federal government for most Medi-Cal Program expenditures.

Medi-Cal is at least three programs in one: (1) a source of traditional health insurance coverage for poor children and some of their parents, (2) a payer for a complex set of acute and long-term care services for the frail elderly and people with developmental disabilities and mental illness, and (3) a wrap-around coverage for low-income Medicare recipients.

Who is Eligible and Summary of Medi-Cal Enrollment: Generally, Medi-Cal eligibles fall into four categories of low-income people as follows: **(1)** aged, blind or disabled; **(2)** low-income families with children; **(3)** children only; and **(4)** pregnant women.

Men and women who are *not* elderly and do not have children or a disability *cannot* qualify for Medi-Cal no matter how low their income. Low-income adults without children must rely on county provided indigent health care, employer-based insurance or out-of pocket expenditures or combinations of these.

Generally, Medi-Cal eligibility is based upon family relationship, family income level, asset limits, age, citizenship, and California residency status. Other eligibility factors can include medical condition (such as pregnancy or medical emergency), share-of-cost payments (i.e., spending down to eligibility), and related factors that are germane to a particular eligibility category. States are required to include certain types of individuals or eligibility groups under their Medicaid state plans and they may include others—at the state's option.

The Medi-Cal Program also has several "special programs" that provide limited services for certain populations**.** These include the **(1)** Emergency Medical Services Program which provides emergency medical services to undocumented individuals; **(2)** the Family PACT Program which provides reproductive health care services; **(3)** the Breast and Cervical Cancer Program which provides services related to cancer for women up to 200 percent of poverty; **(4)** the Disabled Working Program which allows certain disabled working individuals to pay a premium to buy into the Medi-Cal Program; and **(5)** the Tuberculosis Program which provides treatment for TB. These programs are limited in their eligibility and in the services that are funded under them.

As summarized below, Medi-Cal has the following general categories of eligibility. It should be noted that Medi-Cal eligibility is complex and that California has over 120 individual Aid Codes for eligibility tracking purposes.

Medi-Cal Program	Income Level Based on Federal Poverty	Comments
Pregnant Women	Up to 200 percent of poverty	Medi-Cal funds about 500,000 births annually.
Infants aged zero to one year	Up to 200 percent	
Children ages one through 5 yrs	Up to 133 percent	Healthy Families Program covers above 133 percent.
Children ages 6 through 18 yrs (up to age 19)	Up to 100 percent	Healthy Families Program covers above 100 percent for these children. Families with two children maybe "split" between programs due to age.
Parents	Up to 100 percent	Parents who are "undocumented" receive only emergency care.

Medi-Cal provides health insurance coverage to about 18 percent of Californians. The projected Medi-Cal eligible caseload is shown in the table below.

Summary of Caseload Medi-Cal Eligibles	2007-08	2008-09	Caseload Change	Percent Change
Families/Children	**4,821,000**	**4,699,000**	**-122,000**	**-2.6%**
CalWORKS	1,179,000	1,179,000	no change	no change
Working Families	2,981,000	2,871,000	-110,000	-3.8%
Pregnant Women	214,000	220,000	6,000	2.7%
Children	447,000	429,000	-18,000	-4.2%
Aged/Disabled	**1,744,000**	**1,790,000**	**46,000**	**2.6%**
Aged	671,000	691,000	20,000	2.9%
Disabled	1,073,000	1,099,000	26,000	2.4%
Undocumented Persons	**71,000**	**73,000**	**2,000**	**2.7%**
TOTALS	6,636,000 people	6,562,000 people	-74,000	-1.1%

Summary of Budget: Total Medi-Cal expenditures of $36.4 billion (total funds) are proposed for 2008-09, including both state support and local assistance.

The Governor proposes total General Fund expenditures of $13.7 billion in local assistance for 2008-09. This reflects a net General Fund decrease of $402 million or 2.9 percent below the revised current-year level as shown in the chart below. The Governor's spending plan proposes significant adjustments and policy changes that reduce spending in the budget year. These issues will be discussed over the course of several budget hearings.

Medi-Cal General Fund Summary	2007-08 Estimated	2008-09 Proposed	Difference	Percent
Local Assistance				
Benefits	$13,184,000,000	$12,829,000,000	-$354,000,000	-2.8%
County Admin (eligibility)	$786,000,000	$734,000	-$52,000,000	-7.1%
Fiscal Intermediaries (claims processing)	$101,000,000	$105,000	$4,000,000	3.8
Total Local Assistance	**$14,071,000,000**	**$13,668,000,000**	**-$402,000,000**	**-2.9%**
DHS Operations	**$129,000,000**	**$132,000,000**	**$3,000,000**	**2.3%**
Caseload	6,636,000 people	6,562,000 people	-74,000	-1.1%

Legislature's Special Session Actions. After numerous hearings convened by both the Senate and Assembly, the Legislature took action to reduce the current-year shortfall of $3.3 billion and converted it into a little over $1 billion in General Fund reserve.

In addition, the resulting projected budget year deficiency was reduced by $7 billion, leaving an estimated shortfall of almost $8 billion at this time. In addition, the actions of the Legislature provided $8.6 billion in cash management solutions to enable the state to maintain its ability to pay its bills.

With respect to actions taken regarding the Medi-Cal Program, the Legislature adopted the Governor's 10 percent rate reduction to Medi-Cal, with specified modifications, and all of the Governor's proposals regarding cash management. Detail regarding these proposals is contained within the enabling Special Session legislation, AB 3 (xxx) and AB 5 (xxx).

(Vote Only items begin on the next page.)

B. Issues for "Vote Only"—Department of Health Care Services (Through Page 18)

1. Various Reductions to State Support.

Issue. The Governor has proposed reductions to DHCS state support. Most of the reductions identified by the DHCS are from eliminating state staff positions and reducing operating expenses. These are shown in the table below.

Governor's Reductions for State Support

Description of Reduction	General Fund Savings 2008-09
1. Reduce positions in Pharmacy Benefits Division	$231,000
2. Reduce positions in Utilization Management Division	$529,000
3. Reduce positions in Safety Net Care Pool Division	$181,000
4. Reduce positions in Medi-Cal Eligibility—Policy B section (Leaves 12 remaining staff)	$99,000
5. Reduce positions in Systems of Care Division	$194,000
6. Reduce positions in Long-Term Care Division	$620,000
7. Reduce HIPAA contract funding	$482,000
8. Reduce contract funding in Managed Care Division	$937,000
9. Reduce positions in Managed Care Division	$292,000
10. Reduce positions in Fiscal Intermediary Information Technology Management	$415,000
11. Reduce positions in Fiscal Intermediary Project Management/Contract Section/Internal Operations	$588,000
12. Reduce positions in Fiscal Intermediary—Medi-Cal Dental Services	$133,000
13. Reduce positions in Medical Case Management Program	$548,000
14. Reduce positions, travel, and minor contract costs in the Executive Directors area	$182,000
TOTAL GENERAL FUND REDUCTION	**$5,431,000**

Subcommittee Staff Recommendation—Adopt Governor's Reductions Shown in Table. No issues have been raised regarding these proposed reductions to state support.

It should be noted that the Governor has proposed additional reductions to the DHCS state support item. These additional issues will be reviewed by the Subcommittee at a later date.

2. In Home Supportive Services Waiver—Extend State Staff

Issue. The DHCS proposes an increase of $389,000 ($195,000 General Fund) to permanently establish 4 positions—an Associate Governmental Program Analyst, a Health Program Specialist, a Health Program Auditor III and an Accounting Officer—which expire as of July 1, 2008.

The Legislature originally approved these positions on a two-year limited-term basis to administer the In Home Supportive Services (IHSS) Waiver which was approved by the federal CMS in July 2004. The IHSS Waiver is overseen by the DHCS in its role as the single state Medicaid (Medi-Cal) agency as required by federal law. Specifically the DHCS is required to monitor the health and safety of Waiver participants, oversee the financial aspects of the program and ensure cost neutrality.

Background—Summary of IHSS Waiver. This Waiver enables CA to obtain federal matching funds through Medicaid (Medi-Cal) for (1) provider wage payments to the parents of minor children and to spouses of IHSS; (2) advance payments to individuals who hire and train their own caregivers; and (3) restaurant meal allowances for individuals with physical or mental impairments who cannot prepare meals at home. The existing Waiver is set to expire June 30, 2009.

Subcommittee Staff Recommendation—Modify the Request. This is an important waiver for the state and it needs to be maintained using existing staffing levels. However, in lieu of permanent positions, it is recommended to simply extend the existing positions for two more years. This enables the Legislature to have more oversight regarding the program.

3. Breast and Cervical Cancer Treatment Program-- Extend State Staff

Issue. The DHCS proposes an increase of $716,000 ($358,000 General Fund) to permanently establish 7.5 positions—six Associate Governmental Program Analysts, a Staff Services Manager I and an Office Technician—which expire as of July 1, 2008.

The Legislature originally approved these positions on a two-year limited-term basis to provide assistance with a backlog in reviewing certain eligibility redeterminations and related functions.

Subcommittee Staff Recommendation—Modify the Request. These positions are important in order to ensure that eligible individuals are enrolled in the program and receive cancer treatment. However, in lieu of permanent positions, it is recommended to simply extend the existing positions for two more years. This enables the Legislature to have more oversight regarding the program. The LAO is also recommended a two-year limited-term designation.

4. Provider Enrollment—Extend State Staff

Issue. The DHCS proposes an increase of $189,000 ($47,000 General Fund) to extend two positions—two Associate Governmental Program Analysts—to June 30, 2010. These positions are set to expire as of June 30, 2008.

These positions were originally funded by the Legislature on a two-year limited-term basis to reduce a backlog of Medi-Cal provider applications.

Subcommittee Staff Recommendation—Deny Request. The LAO recommends denying this request and Subcommittee staff concurs with the recommendation. This action will save $189,000 (total funds).

SB 857 (Speier), Statutes of 2003, required that all incoming applications be processed within 180 days or the provider be enrolled automatically in Medi-Cal. In addition, regulations were enacted to allow rendering providers to apply to Medi-Cal only one time. Previously, providers within provider groups were required to re-enroll for every group and location where they practiced. These actions have dramatically reduced the backlog and have improved the average application processing time significantly.

C. Medi-Cal Program Issues for Discussion

1. Governor's Proposal to Mandate Quarterly Reporting on Children in Medi-Cal

Issue. The Governor proposes to eliminate annual eligibility for children and to instead, require families to submit status reports on a quarterly basis (three times annually plus a re-determination form) or lose Medi-Cal Program enrollment. About 472,000 children would be affected by this proposal overall.

A total reduction of $167.1 million ($83.5 million federal funds) is assumed with a July 1, 2008 implementation date. These savings would be achieved from the disenrollment of 157,400 children from Medi-Cal, primarily for the failure of their families to return a quarterly status report.

This level of disenrollment assumes that 37 percent of the affected families will fail to return a quarterly status report. Children would be dropped from Medi-Cal enrollment if a quarterly status report is not received, even if they are still eligible for Medi-Cal.

The Administration's savings level does *not* take into consideration increased costs for county administration (either staffing or changes to county eligibility information systems), or cost shifting between the Medi-Cal and Healthy Families programs.

The Governor's proposal requires: (1) statutory changes; (2) emergency regulation authority; (3) changes to county eligibility systems; (4) increased county administrative workload; and (5) a Medi-Cal State Plan Amendment.

How Would the DHCS Quarterly Status Report Proposal Work? Under the DHCS proposal, families participating in Medi-Cal only (non-cash aid) would be required to complete quarterly status reports every three months even if there is no change in the families' circumstance. Medi-Cal coverage is discontinued if the form is not returned. According to the DHCS, a Medi-Cal enrollee has 60-days to return their quarterly status report form before they are terminated from the program. The specific steps are as follows:

- First, if a Medi-Cal enrollee does not return their quarterly status form within 20 days, the County is required to send a "notice of action" to their home;
- Second, the Medi-Cal enrollee then has an additional 10 days to submit the form.
- Third, if the form is still not received by the County, then the Medi-Cal enrollee is placed on hold for 30-days. (In essence, if the child tries to obtain services using their Medi-Cal card, it will not work.) At the end of this 30-day period, the Medi-Cal enrollee is terminated unless the form is returned.

The table below illustrates the paper trail for quarterly status reporting as compared to annual redeterminations.

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Month Medi-Cal granted	Start of QSR report cycle		**QSR Mail Month** (QSR mailed by 10th)	**QSR Due Month** (QSR due by 5th)		**QSR Mail Month** (QSR mailed by 10th)	**QSR Due Month** (QSR due by 5th)		**QSR Mail Month** (QSR mailed by 10th)	**QSR Due Month** (QSR due by 5th)	
Annual redetermination mailing month	Annual redetermination due month										

Children, who lose coverage due to the non-return of the quarterly status report, are subject to a Medi-Cal review as provided under Senate Bill 87 (Escutia), Statutes of 2000. Generally, this requires that in instances when Medi-Cal eligibility has been terminated on one basis, a review must be conducted to determine if the individual is eligible for Medi-Cal under *other* circumstances. All avenues of potential Medi-Cal eligibility are to be reviewed to determine ongoing eligibility.

Therefore, all children disenrolled due to the lack of quarterly status reporting will need to be processed by County Welfare Departments, including an "ex parte" review of other case files the county has on the child, attempted telephone contact with the child's family, and a Medi-Cal form 355.

Potential Affect of Administration's Proposal on Medi-Cal Managed Care. The majority of the children who would be affected by the Administration's quarterly status report are enrolled in Medi-Cal Managed Care plans. Enrollment into Medi-Cal Managed Care has administrative costs associated with it which are in addition to County eligibility processing expenditures.

These include costs of the "health care options" enrollment broker (i.e., Maximus) and costs to the health plan (such as a commercial plan or local initiative plan) for new member processing. Costs to Maximus include those associated with assisting Medi-Cal enrollees in selecting a health care plan and maintaining files of members to be sent to health plans.

The costs to health plans are for updating member files, mailing out their enrollment insurance cards, and ensuring that members have a primary care provider.

Under the existing annual enrollment for children, these administrative costs (i.e., Maximus and health plan administration) are kept to a minimum because "new member" costs are not being incurred on a frequent basis. However, the Administration's proposal would likely increase these costs as children cycle in and out of Medi-Cal (i.e., "churning") and in and out of Medi-Cal Managed Care plans. Based on Subcommittee staff's review of the Medi-Cal estimate, it appears that no adjustments were made to account for any potential changes (either increases or decreases).

Background—Existing Annual Enrollment for Children. California is currently among 15 states that offer an annual eligibility for children. Currently, children determined eligible for Medi-Cal are enrolled for coverage for one-year (i.e., until an annual re-determination form is submitted). The annual redetermination form is a comprehensive document and requires County Welfare Department review and approval. Families are also required to report any changes in income, assets, and related items within ten days during their enrollment period.

Annual enrollment for children has been in operation for over 7 years. Numerous independent analyses have shown its effectiveness because it assists in assuring consistent health care coverage and provides a medical home for comprehensive coverage (most children are enrolled in Managed Care Plan arrangements).

Independent analyses have also shown that annual enrollment for children serves to focus limited state dollars on direct health care services versus administrative paperwork and shifting between programs (i.e., Medi-Cal and Healthy Families).

Background—Report: "How Much Does Churning in Medi-Cal Cost?" This report, published in April 2005 by Dr. Gerry Fairbrother, examined the stability of children's enrollment in both Medi-Cal Fee-for-Service and Medi-Cal Managed Care. Specifically, an analysis was done using California's data on children who are disenrolled, subsequently re-enrolled, and the costs to the state of processing and re-processing applications for the same eligible children. Key findings of this report are as follows:

- Stability in health care is important for optimum quality. Because health care plans participating in Medi-Cal Managed Care are held accountable for children enrolled at least one-year according to the standard "Health Plan Employer Data and Information Set" (HEDIS), the one-year mark is an important one. It is generally thought that less than one year is not enough time to show improvement. Beyond reporting and accountability, one year has come to represent the minimum amount of time to bring about quality improvement.

- In California, three out of four Medi-Cal children (75 percent) had been enrolled in the same health plan for one or more years, and are part of the Medi-Cal Managed Care reporting. This is striking since Managed Care as a delivery system has enormous potential for monitoring and intervening in care for a large proportion of poor children.

- About 20 percent of the children in the study were disenrolled at least once in the course of the three years of data analysis, but subsequently regained Medi-Cal coverage. Most of the children disenrolled from Medi-Cal and subsequently re-enrolled, did so *within four months.*

- The fact that the breaks in Medi-Cal coverage were relatively short suggests that children probably remain eligible and lost coverage for other reasons, such as having trouble navigating the complexities of Medi-Cal Program renewal. "Churning" is important because if the same eligible children are being enrolled and re-enrolled, then inefficiencies are introduced and quality of care may be adversely affected.

- Churning has significant implications for cost, in that administrative dollars to process applications diminish funds available for actual coverage. In times of fiscal constraint, it is especially important to focus limited funding on health care, rather than administration.

- Based on information provided by the Administration, the study identified about $200 in costs per child (in 2005) for processing children into Medi-Cal and subsequently into Medi-Cal Managed Care. This means that California spent over $120 million to re-process eligible children over a three-year period or about $30 million annually.

Legislative Analyst's Office Recommendation. The LAO has no issue with the Governor's proposal to mandate quarterly status reporting for children. However they have made an adjustment to the proposed reduction to account for increased costs caused by children re-entering Medi-Cal when services are needed. Therefore the LAO assumes a combined savings of $138 million ($69 million General Fund) from this proposal and the Administration's proposal regarding adults (Agenda issue 2, below).

Subcommittee Staff Comment and Recommendation—Hold Open. There are several concerns with this proposal. First, it would create an inequity with the Healthy Families Program. The Healthy Families Program provides annual eligibility for children with family incomes which are generally higher than Medi-Cal families. There should be continuity between the programs for ease of shifting children, when applicable, between the two

programs to maintain uninterrupted coverage. Instituting a change in Medi-Cal would be clearly biased.

Second, there are various independent reports, including some that have specifically used California data, which note the importance of health care coverage for children and the need to have a medical home, such as that offered through Medi-Cal Managed Care plans. Managed Care as a delivery system has enormous potential for monitoring and intervening in care for a large proportion of poor children. HEDIS data is tracked based on annual enrollment because it usually takes a year to have measurable outcomes. "Churning" would occur if the quarterly status reports are reinstituted which in turn would negate many of the principles of a Managed Care approach. In fact, a federal review conducted of California in 2000 expressed grave concerns that a significant number of Medi-Cal individuals were losing coverage because quarterly status reports were not being returned (comment made prior to implementation of the annual eligibility process).

Three, the adoption of annual eligibility for children 7 years ago was intended to ensure continuity of health care and to reduce over time Medi-Cal administration costs in order to make the program more efficient and effective. If the quarterly status reports are reinstated, counties will need more funding to re-program computer systems, train eligibility workers and hire additional staff to process additional paperwork. Increased funding over time will also be needed for the "health care options" contractor (i.e., Maximus), as well as for managed care plans for member enrollment activities. This is particularly true with the need for the state to do "SB 87" processing as referenced above.

Fourth, some of the data available from the DHCS shows that disenrolled children are often re-enrolled when they need health care services. As such, there is a likelihood that utilization of services within Managed Care plans will not decline as much as caseload. This will result in a higher utilization per enrollee and a higher capitation rate overall that will offset a portion of the DHCS' assumed caseload savings.

Fifth, California still has over 750,000 uninsured, low-income children. We provide funding under the Healthy Families Program to conduct outreach to enroll more children and to maintain their enrollment. As such, the Administration's proposal is completely counterintuitive to conducting outreach and the related measures to ensure eligible children's enrollment in public programs.

It is recommended to hold this issue open pending receipt of additional information.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief description of the proposal, including how the savings level was determined.
2. DHCS, Specifically what information will be required to be completed on the quarterly status reporting form under this proposal?
3. DHCS, Would the "SB 87" processing still be required under the proposal?
4. DHCS, Why is emergency regulation authority being requested?

2. Governor's Proposal to Shift Adults from Semi-Annual to Quarterly Reporting

Issue. The Governor proposes to eliminate semi-annual eligibility for parents and to instead, require parents to submit status reports on a quarterly basis (three times annually), along with an annual re-determination form, or lose Medi-Cal Program enrollment.

A total reduction of $17.2 million ($8.6 million General Funds) is assumed with a July 1, 2008 implementation date. These savings would be achieved from the disenrollment of parents from Medi-Cal, primarily for failure to return a quarterly status report. Parents would be dropped from Medi-Cal enrollment if a quarterly status report is not received, even if they are still eligible for Medi-Cal.

The Administration's savings level does *not* take into consideration increased costs for county administration or Medi-Cal Managed Care plan administration (such as member enrollment as discussed above under Agenda issue #1).

This change requires: (1) statutory changes; (2) emergency regulations; (3) changes to county eligibility systems; (4) increased county administrative workload; and (5) a Medi-Cal State Plan Amendment.

Medi-Cal populations *not* affected by the proposal include: (1) women who are pregnant and enrolled in the Medi-Cal eligibility "pregnancy" aid codes (however, women who are enrolled in the 1931 (b) eligibility category and then become pregnant would be affected by this proposal); (2) CalWORKS-linked adults (they already have CalWORKS paperwork requirements); and (3) aged, blind and disabled eligibility categories.

Background—Existing "Semi-Annual" Eligibility for Parents. Currently, parents determined eligible for Medi-Cal are enrolled for coverage for six months. They must submit a semi-annual status report to continue enrollment for an additional six months. At the one year anniversary of enrollment, parents must submit a comprehensive annual redetermination form to continue enrollment. Families are also required to report any changes in income, assets, and related items within ten days during their enrollment period.

Semi-annual reporting for parents has been in use for over 5 years (plus about two-years of annual eligibility). It assists in assuring, where applicable, uninterrupted health care coverage and serves to focus limited state dollars on direct health care services versus administrative paperwork.

Legislative Analyst's Office Recommendation. The LAO has no issue with the Governor's proposal to eliminate "Semi-Annual" reporting and mandate quarterly status reporting for adults. The LAO assumes a combined savings of $138 million ($69 million General Fund) from this proposal and the Administration's proposal regarding children (Agenda issue 1, above). The LAO made a technical adjustment in the Governor's proposals to account for increased costs caused by people re-entering Medi-Cal when services are needed; a reduction of $23 million was reflected for this.

Subcommittee Staff Comment and Recommendation—Hold Open. This issue parallels the Administration's proposal mandating a quarterly reporting process for children. As such, the concerns previously expressed are similar.

In the February 4th hearing, convened by the Senate Budget & Fiscal Review Committee, questions were raised regarding the availability of Semi-Annual reporting data. The California Welfare Directors Association (CWDA) has provided information from counties that represent about 85 percent of the statewide Medi-Cal enrollment caseload. Based on this data, the CWDA reports that of the 34,194 adults whose Medi-Cal cases were discontinued due to incomplete reporting or failure to return the Semi-Annual report (1) 22,393 or 70 percent of the adults were back on Medi-Cal within less than a year; and (2) ninety percent of the 22,393 cases had actually returned to Medi-Cal *within the first 90-days* after being discontinued. As such, there is "churning" within the adult Medi-Cal population as well. Implementation of a quarterly status report (versus the existing semi-annual) would likely increase this "churning".

Further, given the level of assumed savings from this proposal, and the lack of accounting for likely additional administrative costs (i.e., county processing costs, health care options costs and Managed Care member costs), there is question as to what true level of savings would be achieved from this action on an annual basis.

It is recommended to hold this issue open pending receipt of additional information.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief description of the proposal, including how the savings level was determined.
2. DHCS, Specifically what information will be required to be completed on the quarterly status reporting form under this proposal?
3. DHCS, Would the "SB 87" processing apply under this proposal? If not, why not please?

3. Governor's Proposals to Substantially Reduce County Eligibility Processing

Issue. The Governor is proposing to substantially reduce funding provided to County Welfare Departments for Medi-Cal Program eligibility processing. The reductions are shown in the table below.

Governor's Proposals to Reduce Funds for County Eligibility Processing

Description of Governor's Proposal	General Fund Reduction	Total Fund Reduction
A. Reduce "Base Allocation"	-$15.3 million	-$30.6 million
B. Eliminate CA Necessities Index Adjustment	-$22.4 million	-$44.8 million
C. No funding for new caseload	-$33.4 million	-$66.8 million
TOTAL REDUCTION	**-$71.1 million**	**-$142.2 million**

A. Reduce "Base Allocation" (-$30.6 million total funds). The Governor proposes to reduce the base allocated used to fund County staff to conduct Medi-Cal eligibility processing, including intake and re-determination work with people applying for Medi-Cal services.

This represents a 2.5 percent reduction to the base allocation. The savings level assumes a July 1, 2008 implementation date and would require a change in statute and release of an "All County Letter" by the DHCS to implement.

Subcommittee staff notes that this proposed reduction was backed into by the Administration in order for the DHCS to meet the fiscal target proposed by the Governor. In addition, reducing the base allocation would likely result in delays and inaccuracies in eligibility determinations. Not only would this affect individuals trying to enroll into the program, it would also affect re-determinations by continuing eligibility when one may no longer be eligible for services. Therefore, increased expenditures could potentially result from this proposal.

B. Eliminates Funding for CA Necessities Index Adjustment (-$44.9 million total funds). Through agreements made in the Budget Act of 2003, as noted below in the background section, the Administration has been providing certain adjustments to counties to ensure appropriate funding levels to maintain eligibility processing staff to meet County Performance Measures.

The Governor proposes to eliminate the CA Necessities Index (CNI) funding of $44.9 million ($22.5 million General Fund) to recognize the counties "cost of doing business" (i.e., an allowable allocation for county salary adjustments). The $44.9 million (total funds) is calculated by taking the base for 2007-08 allocation and multiplying it by the index. (DOF calculates the CNI to be 3.66 percent for 2008-09).

Subcommittee staff notes that reducing state funding for county salary adjustments may make it more difficult for counties to hire and retain staff, and may lead to holding County eligibility positions vacant due to funding shortfalls.

C. No Funding for New Caseload (-$66.8 million total funds). The Governor proposes to reduce funding for County staff to conduct Medi-Cal eligibility processing which is allocated to counties based on projected Medi-Cal caseload levels. Specifically, the Administration is not funding counties to process new caseload for Medi-Cal in 2008-09.

Funds allocated to counties for caseload growth enable counties to hire additional staff to handle increased workload associated with additional people applying for Medi-Cal enrollment. Without this funding, longer waits for Medi-Cal enrollment and health care assistance will likely occur.

Subcommittee staff notes that this proposal would also affect County Performance Measures as describe below. It is unrealistic for the DHCS to assume that counties can meet Medi-Cal eligibility processing timelines if appropriate funding is not provided to address staffing needs.

Summary of Funding for County Administration (Eligibility Processing). Counties receive funding from the state to conduct eligibility determinations and annual redeterminations and to maintain each Medi-Cal enrollee case throughout the year. The funding ratio for these activities is 50 percent General Fund, along with the federal matching funds. The table below summarizes the funding for County Administration processing.

Summary of Funding for County Administrative Processing for Medi-Cal Program

	Actual 2006-07 General Fund Amount	Estimated 2007-08 General Fund Amount	Governor's Proposed 2008-09 General Fund
County Administration	$673 million	$786 million	$734 million
Caseload	6.544 million	6.638 million	6.564 million

***Background on County Welfare Departments and Medi-Cal Program*.** County Welfare Departments serve as a surrogate for the state in administering the Medi-Cal eligibility determination process for all people applying for enrollment and all aspects of enrollment redeterminations. Counties receive funding from the state to conduct eligibility determinations and redeterminations and to maintain each case throughout the year.

In the Budget Act of 2003, a compromise between the Legislature, Administration and County Welfare Departments was achieved. This agreement resulted in a reduction of $376 million (total funds) in county Medi-Cal administrative funding and implementation of "County Performance Standards". On-going savings from this action are estimated to save the state *at least* $450 million ($225 million General Fund) annually.

The County Performance Standards are in statute and require all 58 counties to meet specified processing requirements. Counties that are out of compliance with any of the

compliance criteria must enter into a Corrective Action Plan with the DHCS for improving performance. If a county fails to improve its performance, the DHCS can penalize the county up to 2 percent of its annual Medi-Cal eligibility allocation for the following year.

Additional County Performance Standards have been added to statute since this time, including criteria for standards that bridge Medi-Cal with the Healthy Families Program and for the processing of certain DHCS alerts related to the Medi-Cal Eligibility Determination System (i.e., the state's data bank on Medi-Cal eligibility).

Concerns from Constituency Groups. The Subcommittee is in receipt of letters from constituency groups expressing concerns with the Administration's proposal. First, the County Welfare Directors Association expresses significant concerns with these proposals. They note the proposed reductions are completely counter to the County Performance Measures implemented in 2003 and would result in counties not being able to meet the requirements.

Further, the proposed reduction in the base allocation and caseload growth would severely under fund the system and lead to (1) people not receiving their Medi-Cal eligibility in a timely manner, (2) counties not meeting federally required annual redeterminations, and (3) children losing health care coverage because they cannot be appropriately transitioned to the Healthy Families Program (i.e., the bridge from Medi-Cal to Healthy Families is done by the counties).

Other constituency groups have expressed concerns because Medi-Cal enrollees will have difficulty reaching their County case workers when needed, and providers will not be able to verify Medi-Cal enrollee information on demand as presently done through the counties.

Subcommittee Staff Comment and Recommendation—Hold Open. The Administration has *not* offered a comprehensive approach in its series of reductions targeting County Administration. Further, all of the proposals would directly affect the ability of County Welfare Departments to meet the statutorily required County Performance Measures. Presently the state saves *at least* $450 million ($225 million General Fund) from the performance measures. As such, the Administration's proposal places these existing savings at risk.

Though there have been numerous discussions with the DHCS regarding making improvements to the Medi-Cal eligibility process, the DHCS has accomplished little in this regard. The Medi-Cal Manual (over 1,000 pages) which county eligibility workers must use is *not* current, and the DHCS has not completed regulations for many years. In addition, there have been over 593 "All County Letters" over the past 10 years which contain instructions to the counties. Three sources of information must be searched and clarified in many instances for counties, as well as advocates, to understand the Medi-Cal Program. Plus there is state law and federal law to interpret.

Clearly the DHCS needs to be a better business partner. The state could undertake a review of the Medi-Cal Program manual, regulations and All County Letters to provide

increased clarity and structure and improve efficiency. Some of these components should be included in any reduction discussion regarding county administration.

It is recommended to hold this issue open pending receipt of additional information.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary of the three proposals.
2. DHCS, If these proposals are implemented, can the state still meet federal minimum requirements for processing Medicaid (Medi-Cal) applications?
3. DHCS, Please explain from your perspective why these reductions would or would not affect savings the state currently obtains from County Performance Standards.
4. DHCS, What short-term changes can the state do to facilitate the counties ability to process Medi-Cal eligibility changes more effectively?

4. Cessation of Payment for Part B Premiums for Share-of-Cost Individuals

Issue. The Governor proposes to eliminate the state's payment of the Medicare Part B Premium for individuals who are enrolled in Medi-Cal with a share-of-cost *and* do not meet their share-of-cost every month.

Specifically, the DHCS would no longer pay the Part B premiums of about $100 per month for individuals enrolled in Medi-Cal with a "share-of-cost" who are Medicare entitled (i.e., adjusted income exceeds 129 percent of poverty) but do *not* meet their monthly share-of-cost requirement under the Medi-Cal Program. The DHCS states there is no federal requirement to pay Part B premiums for these individuals.

There are about 57,000 individuals, primarily aged, blind and disabled with income above 129 percent of the federal poverty level who would be affected by this proposal. These individuals would either need to pay the Part B Premium on their own to maintain the Medicare outpatient services coverage, *or* pay out-of-pocket for outpatient medical services until they meet their share-of-cost requirement in Medi-Cal. If an individual meets the Medi-Cal share-of-cost requirement, the DHCS would pay the person's Part B Premium the following month.

The DHCS assumes savings of $66.5 million (General Fund) in 2008-09 with an implementation date of July 1, 2008. Federal matching funds are not applicable to this proposal. The proposal requires trailer bill legislation to implement.

Background on Medicare Part B Premiums (Outpatient Services). Currently, California participates in a "buy in" agreement with the federal government whereby our Medi-Cal Program automatically pays the federal Medicare Part A (inpatient) *and* Part B premiums (outpatient) for all Medi-Cal enrollees who have federal Medicare entitlement. This "buy-in" allows California to defer certain Medi-Cal expenditures to the federal government's Medicare Program and therefore, saves General Fund expenditures.

With respect to the Part B Premium Program, Medi-Cal automatically pays Part B premiums for all Medi-Cal enrollees who have Medicare Part B entitlement in the following groups:

- Full scope Medi-Cal recipients, who are currently both Medicare Part B entitled and Medi-Cal eligible with no share-of-cost.
- Medicare Savings Program individuals, who are not on Medi-Cal, but who qualify for Medicare premium payments under federal income and asset rules.
- Medi-Cal "share-of-cost" individuals who are Medicare entitled but whose adjusted income exceeds the federal income poverty limit of 129 percent of poverty. This is a "state-only" program. There is no federal requirement for the payment of Medicare premiums for this group of individuals. (This is the group that is proposed for elimination by the DHCS if they do not meet their monthly share-of-cost. Generally, Medi-Cal share-of-cost individuals have income levels that are too high to qualify for full-scope Medi-Cal services at no-cost to them; therefore, they need to spend out-of-pocket for some of their health care costs.)

Special Session Action. The Governor included this proposal as part of his Special Session package. It was not adopted by the Legislature for the current year. The budget year issue remains under discussion.

Legislative Analyst's Office Recommendation—Adopt Governor's Proposal. The LAO recommends to adopt the Governor's proposal and to capture the $66.5 million (General Fund) savings for the budget year. The LAO believes this reduction proposal would have a lesser effect on the provision of direct care services than some other alternatives proposed by the Governor. Further, they note that for other "share-of-cost" programs the state generally does not provide a benefit until an individual meets their share-of-cost.

Subcommittee Staff Comment and Recommendation—Hold Open. Generally, the issue at hand is whether the state is reaping any cost-benefit by paying Part B Premiums for certain individuals. Historically, the state has paid Medicare premiums (both "A" for inpatient services and "B" for outpatient services) because it was cost-beneficial for the state to do so since it shifted some medical expenditures from Medi-Cal to Medicare (100 percent federally funded).

However, the DHCS contends that the state does not save General Fund support within Medi-Cal through the payment of Part B Premiums for share-of-cost individuals (as a category). The DHCS states that these individuals have an average share-of-cost of *over* $500 per month (i.e., the person has to spend this much on medical expenses to be eligible for Medi-Cal) and the average outpatient cost for this population is less than $300 per month.

This means on average, the share-of-cost individual would not meet their share-of-cost so the state does not save General Fund when it pays the monthly Part B Premium on a regular basis. This is because the state would pay $100 for the premium but the individual would not be eligible for Medi-Cal and Medi-Cal would not have had to pay for any outpatient services since the share-of-cost was not meet.

Under the DHCS proposal, if an individual meets their share-of-cost, the state would then pay the Part B Premium for the month following the first month that they meet the share-of-cost and then continue until they don't meet the share-of-cost. The DHCS believes this approach is cost-beneficial because outpatient costs which would be "owed" by Medi-Cal would be shifted to the Medicare Program. According to DHCS data, about 16 percent of the existing share-of-cost individuals actually meet their share-of-cost each month.

It should be noted that the DHCS has not provided any details as to how their proposal would functionally operate if adopted by the Legislature. This information needs to be provided.

In an effort to maintain more of a safety net approach for people, the Subcommittee may want to consider an approach whereby the state continues to pay an individual's Part B Premium if their share-of-cost is *under* $500. For example, individuals with a $200 monthly share-of-cost have monthly incomes of $820 ($9,840 annually). As such, a monthly Part B Premium represents a considerable cost for aged and disabled individuals. This safety net

approach would reduce the Administration's savings by $4.6 million (General Fund) but would help ensure that very low income, aged and disabled individuals are assisted.

At this time, it is recommended to hold this issue open to obtain more information.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. **DHCS**, Please provide a brief description of the proposal, *and* how it would functionally operate.

5. Proposed Elimination of Adult Dental Services

Issue. The Governor proposes to discontinue dental services for adults 21 years of age or older, including pregnant women and individuals with developmental disabilities. Only adults in nursing facilities would continue to receive services because these services are federally required. In addition, dental services provided to children would not be directly affected because federal law requires these services.

The Governor proposed this action through the Special Session but the current year change was not adopted by the Legislature. For the budget year, a reduction of $229.9 million ($114.9 million General Fund) is assumed with an implementation date of July 1, 2008. This proposal requires a change in statute, regulatory changes and a Medi-Cal State Plan Amendment.

It should be noted that the Department of Developmental Services (DDS), which services individuals with developmental disabilities, would need to provide dental services at 100 percent General Fund expenditure if these DHCS Medi-Cal Program services are eliminated. The Governor's budget proposal however does not account for these costs. According to the DDS, an increase of $4.680 million (General Fund) would be needed to provide these services. Therefore the Governor's proposed savings for this issue should be reduced by this amount to account for this need.

Further as noted below, Denti-Cal services were reduced by the Governor under his 10 percent rate reduction proposal which was adopted by the Legislature in the Special Session. This reduction equates to about a $60.3 million ($30.8 million General Fund) amount for 2008-09. The DHCS did not account for the confounding affects of this rate reduction and their proposed elimination of Adult Dental services. As such, a technical adjustment would be needed to this proposal if adopted by the Legislature to account for this interaction.

The DHCS notes that lack of dental treatment often results in emergency room visits which results in a shift and increase to medical and hospitals costs.

Legislature's Special Session Actions. The Governor proposed a 10 percent rate reduction to health care services provided under the Medi-Cal Program. The Denti-Cal Program was included in this rate reduction which will be effective as of July 1, 2008.

Background—Dental Services. Medi-Cal's dental program—"Denti-Cal"-- provides primary and specialty dental care for adults and children. Adult dental care is provided at the state's option and is not federally required, except for adults in nursing homes, but is federally reimbursed. Six other states besides California provide these services to adults. Federal law requires states to provide dental services to children.

According to the most recent actual expenditures from 2005-06, Denti-Cal expenditures were $553.7 million (total funds). Of this amount, $266.3 million in expenditures, or 48 percent, were for services to children. The remaining $287.4 million in expenditures were

for adults. Of the amount expended for adults, $140.1 million, or 48 percent, was for adults who are in the aged, blind and disabled Medi-Cal eligibility category.

Therefore, 74 percent of the Denti-Cal Program expenditures are for children and aged, blind and disabled adults.

Denti-Cal operates using strict cost containment requirements. Recent changes enacted to reduce expenditures include: **(1)** pre-treatment x-rays to justify restorations; **(2)** restricted use for certain laboratory processed crowns; **(3)** increased provider enrollment requirements; **(4)** reduced payment for periodontal deep cleaning; and **(5)** an $1,800 annual cap for adult services. In addition as noted above, a 10 percent rate reduction to all dental procedures provided under Denti-Cal will be effective as of July 1, 2008.

It should be noted that the Department of Developmental Services (DDS), which services individuals with developmental disabilities, would need to provide dental services at 100 percent General Fund expenditure if these DHCS Medi-Cal Program services are eliminated. It is estimated that this would cost about $4.680 million (General Fund) in 2008-09.

Subcommittee Staff Comment and Recommendation—Hold Open. The importance of dental care and oral health has been analyzed and highlighted in many recent reports. The Surgeon General has reported that oral health problems can cause infection and signal trouble in other parts of the body. Periodontal (gum) disease in pregnant women has been associated with pre-term and low-birth weight babies, diabetes, cardiovascular disease, stroke, and bacterial pneumonia. Left untreated, dental disease can result in severe pain and infection leading to various health problems, and difficulty with the activities of daily living.

Based on a recent report (May 2007) by the CA Healthcare Foundation, about 40 percent of private dentists practices in California accept Denti-Cal reimbursement.

The DHCS notes that lack of dental treatment often results in emergency room visits which results in a shift and increase to medical and hospitals costs.

It is recommended to leave this issue open pending receipt of additional information.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1 DHCS, Please provide a brief summary of the proposal.

2 DHCS, What is the potential for other expenditures within the Medi-Cal Program to increase due to the elimination of Adult Dental services?

6. Governor's Proposal to Reduce Funding to Public Hospitals to Backfill for General Fund Support in Certain State-Operated Programs

Issue. The Governor proposes to shift federal funds designated for uncompensated care for Public Hospitals, as contained in the state's Hospital Financing Waiver, to backfill for General Fund support in certain state-operated programs, including the Medically Indigent Adult Long-Term Care Program, the Breast and Cervical Cancer Treatment Program, the California Children's Services (CCS) Program, and the Genetically Handicapped Persons Program (GHPP).

The federal funds would be redirected from the Safety Net Care Pool which is a component of the state's Hospital Financing Waiver. Safety Net Care Pool Funds are capped at $560 million (federal funds) annually and are provided to hospitals for uncompensated care costs, except for $44.5 million which is used by the state to offset General Fund costs in various state-operated programs.

The table below outlines the existing redirection provided to these state-operated programs, along with the Governor's proposed increase in the shift for 2008-09. The Administration is proposing this shift to save General Fund support.

As noted, the existing baseline shift saves the state almost $44.5 million in General Fund support. The Governor's additional shift would save an additional $34.4 million in 2008-09. The combined total would save $78.850 million General Fund for 2008-09.

It should be noted that the annualized shift (effective in 2009-2010), which consists of the existing baseline and the proposed additional shift for 2008-09, would be a total of $98.650 million.

Summary of Governor's Proposed Use of Safety Net Care Pool Funds

Program	Existing Redirection (Baseline)	Additional Shift for 2008-09 (Increase)	Total Amount of Shift for 2008-09	Total Amount Annualized
Medically Indigent--LTC	$18,450,000	$6,726,000	$25,176,000	$23,480,000
Breast & Cervical Cancer	--	$1,024,000	$1,024,000	$1,913,000
CA Children's Services Program	$18,000,000	$17,839,000	$35,839,000	$55,257,000
Genetically Handicapped Persons	$8,000,000	$8,811,000	$16,811,000	$18,000,000
TOTALS	**$44,450,000**	**$34,400,000**	**$78,850,000**	**$98,650,000**

In order to obtain the federal funds available under the state's Hospital Financing Waiver, California must use both state General Fund support and "certified public expenditures" (CPEs) as a match.

A key aspect of this arrangement is that designated Public Hospitals receive federal matching funds based on generated CPEs and intergovernmental transfers. This means that Public Hospitals and counties must spend their own revenues in order to obtain the federal funding that is made available.

Certain expenditures incurred by the state can also serve as CPE for purposes of obtaining federal Safety Net Care Pool Funds. When this is done, the state can save General Fund support by using federal funds as a backfill.

The effect of the Governor's proposal is that fewer funds would be available to Public Hospitals from the Safety Net Care Pool. This could affect access to services by both Medi-Cal enrollees and the uninsured

Background—Summary of Hospital Financing Waiver. As a result of federal policy changes, California was required to completely change its method in which Safety-Net Hospitals (about 146 hospitals) are financed under the Medi-Cal Program. The Administration negotiated a five-year federal Waiver with the federal Centers for Medicare and Medicaid (CMS) which was completed as of September 1, 2005.

The federal requirements for this Hospital Finance Waiver are contained in the *"Special Terms and Conditions"* document which serves as a contract between California and the federal CMS. Senate Bill 1100 (Perata and Ducheny), Statutes of 2005, provides the state statutory framework for implementing the new Hospital Finance Waiver.

Under this new waiver, Public Hospitals will certify their health care expenditures (referred to as "Certified Public Expenditures" or CPE) in order to obtain federal funds, and Private Hospitals will rely solely on the state's General Fund to obtain their federal funds. In addition, Public Hospitals will be able to use Intergovernmental Transfers (IGT's), which was the primary method of funding the state match under the previous financing system, on a *limited basis* to obtain federal matching funds.

The framework of the Waiver is quite complex and consists of several funding mechanisms, including the Health Care Support Fund (i.e., Safety Net Care Pool), Stabilization Funding, Disproportionate Share Hospital (DSH) payments, replacement DSH and replacement Graduate Medical Education payments, Physician Services, Distress Hospital Fund, and Medi-Cal per diem and cost-based payments.

Constituency Letters. The Subcommittee is in receipt of numerous letters, including from the CA Hospital Association of Disproportionate Share Hospital Task Force, in strong opposition to the Governor's additional redirection of federal Safety Net Care Pool Funds.

Legislative Analyst's Proposal—Shift an Additional Amount. The LAO proposes to expand the number of state-operated programs which could obtain funds from the Safety Net Care Pool. Generally, the LAO would shift an additional $20.1 million by claiming federal funds from the Safety Net Care Pool for the Expanded Access to Primary Care Program (EAPC), the Rural Health Services Program, Clinic Grants-In-Aid Program, and the Seasonal and Migratory Workers Clinic Program. This shift would also involve the movement of Proposition 99 Funds (Cigarette and Tobacco Product Surtax Funds).

Subcommittee Staff Comment and Recommendation—Hold Open. First, the Safety Net Care Pool is a capped amount and the federal funding it provides feeds into a series of payments to hospitals which serve a significantly high portion of uninsured people. The purpose of the Waiver was to stabilize funding for these core hospitals and to provide for appropriate growth over the course of the 5-year Waiver period. As such, it is questionable as to whether the Administration's proposal to increase state-operated program support (as noted in the table above) can be implemented and maintained on an annualized basis without threatening the integrity of the overall Waiver.

The state's Hospital Financing Waiver is complex and relies on a series of calculations and funding formula's which are contained in state statute and the various Waiver documents but are also subject to variations contingent upon various point-in-time data-driven information. As such, the Safety Net Care Pool (capped at $586 million federal funds) is used to address the following factors:

- Need for Public Hospital Baseline (at least $325 million draft figure). The Hospital Waiver requires a baseline level of funding adjustment to account for final expenditures incurred as of 2004-05. This is a data-driven calculation and is still pending receipt of information and finalization. But basically, *at least* 55 percent or so of the Safety Net Care Pool is needed to maintain the base. These funds are obtained using Public Hospital CPEs as the state's match.

- Need for South Los Angeles Medical Services Preservation ($100 million). As required in Senate Bill 474 (Kuehl), Statutes of 2007, funds from the Safety Net Care Pool are to be used to maintain a functional safety-net among a grouping of hospitals (mainly private hospitals) due to the closure of Martin Luther King/Harbor Hospital in Los Angeles. This preservation fund is supported by the Safety Net Care Pool.

- Distressed Hospital Fund ($11.8 million). As contained in the enabling legislation of SB 1100, Statutes of 2005, this fund is used to provide an immediate fusion of funding to certain hospitals due to unusual circumstances in an effort to stabilize the hospital's funding. Funds from the Safety Net Care Pool are used for this purpose and are obtained by using state-operated program CPEs as the state's match.

- Budget Neutrality ($32.7 million). Due to the complexities of funding shifts, including the shifting of General Fund support away from Public Hospitals to support Private and District Hospitals, the state identified this amount of the Safety Net Care Pool to be used towards state-operated programs. State generated CPEs are used to draw this amount.

These above items tally to a total of **at least $470 million**. This would leave about $116 million or so available for Stabilization Funding. Stabilization Funding is another aspect of the Waiver and is intended to provide both Public and Private Hospitals with growth funds to account for medical costs, medical training and increased patient care.

Therefore the Administration's proposed increase of $34.4 million to support state-operated programs increases the draw on the Safety Net Care Pool to be a total *annualized* amount of $98.650 million (as shown in the above table). As such, little would be left remaining for hospital Stabilization Funding which was a key component of the five-year Waiver.

Further, the five-year Waiver was structured to require the Public Hospitals to use Certified Public Expenditures (CPEs) in lieu of state General Fund support. The General Fund support was shifted to assist in funding Private and District Hospitals. As such, there was in essence, no state General Fund impact with the Waiver. Yet the DHCS is now proposing to backfill state General Fund with Waiver dollars.

Clearly the Governor's proposal would affect access to services by both Medi-Cal enrollees and the uninsured, including Hospital Outpatient services as well as Hospital Inpatient services.

With respect to the LAO proposal, it creates added complexity that could potentially place the entire Hospital Financing Waiver at risk. The LAO proposal would require a re-opening of the Waiver and a re-negotiation with the federal CMS as well as discussions with diverse hospital groups. Further, Proposition 99 Funds (Cigarette and Tobacco Products Surtax Funds) can be redirected to backfill for General Fund support in other areas. (A discussion on Proposition 99 Funds will be conducted in a future Subcommittee hearing.) Lastly, the proposal would direct additional funds away from core hospital programs.

It is recommended to leave this issue open at this time pending receipt of additional information.

Questions. The Subcommittee has requested a response to the following questions.

1. DHCS, Please provide a summary of the proposal.

2. DHCS, In your view would there be sufficient funding for hospitals under the Waiver without these funds?

3. DHCS, Would there be any need to change state statute, the existing Waiver, or to obtain federal CMS approval of this proposal? Please explain.

7. Governor's Proposal to Reduce Payments for Private Hospitals and Districts

Issue. The Governor proposes to reduce by 10 percent the amount paid to Private Hospitals and District Hospitals under the state's Hospital Financing Waiver by making adjustments to certain disproportionate share hospital payments, including replacement payments, which are paid to these hospitals. A total reduction of $47.3 million ($24 million General Fund) is proposed for 2008-09.

This proposal would, in effect, reduce by 10 percent the amount Private Hospitals and District Hospitals receive in disproportionate share hospital replacement payments. Therefore, these hospitals would receive less reimbursement for their uncompensated care costs.

Under the state's Hospital Financing Waiver, hospitals participating in the Medi-Cal Program receive funds from several sources based on a complex formula. A key aspect of this arrangement is that Public Hospitals receive federal funds based on the use of their certified public expenditures and intergovernmental transfers, whereas Private Hospitals and District Hospitals receive a mixture of state General Fund support and federal funds.

The payments the DHCS is proposing to reduce are "replacement" Disproportionate Share and "replacement" Graduate Medical Expenses. When the Waiver was structured, federal funds which the Private and District Hospitals had received were restructured with the intent of the state to ensure that in the aggregate, these hospitals would receive payments equal to what they received in 2004-05 (i.e., prior to the Waiver).

As such, the Governor's proposal would reduce the overall funding level available to these hospitals under the Waiver.

Subcommittee Staff Comment and Recommendation—Hold Open. This Governor's proposal would reduce the amount of funding Private and District Hospitals receive for uncompensated care reimbursement. It also dilutes the Governor's original Waiver arrangement with these hospitals.

Clearly the Governor's proposal would affect access to services by both Medi-Cal enrollees and the uninsured, including Hospital Outpatient services as well as Hospital Inpatient services.

Questions. The Subcommittee has requested a response to the following questions.

1. DHCS, Please provide a brief summary of the proposal.
2. DHCS, In your view would there be sufficient funding for hospitals under the Waiver without these funds?
3. DHCS, Would there be any need to change state statute, the existing Waiver, or to obtain federal CMS approval of this proposal? Please explain.

8. LAO--Implement Public Assistance and Reporting Information System (Discussion Purposes)

Issue. The LAO in their alternative budget proposal states that a savings of $7 million (General Fund) can be achieved in 2008-09 by having the DHCS begin implementation of using the Public Assistance and Reporting Information System (PARIS).

This is the second year in which the LAO has raised the issue of having the DHCS precede with implementation of PARIS.

In Supplemental Report Language of the Budget Act of 2007 directs the DHCS to provide the Legislature with the following two reports:

- A report examining the implementation of PARIS in order to allow DHCS to identify veterans enrolled in the Medi-Cal Program who could instead receive medical benefits through the federal Veteran's Administration. This is due as of April 1, 2008. (It has not yet been provided to the Legislature at the time of this writing.)

- A report examining the implementation of the PARIS interstate/federal match to allow California to identify enrollees who are receiving duplicate benefits from health and social services programs in two or more states and thereby facilitate improved program integrity by disenrollment of enrollees upon verification that they are no longer reside in California. This is due as of July 1, 2008.

Background—PARIS. The Public Assistance Reporting Information System (PARIS) is a federal computer data matching process to help states share information with one another about individuals enrolled in state and federal health and social services programs. It identifies public assistance recipients in participating states who are eligible for federal benefits, including Veterans Affairs benefits. The process also identifies individuals who are simultaneously enrolled in and receiving benefits from Medicaid, SSI/SSP, CalWORKS, and Food Stamps in more than one state.

Questions. The Subcommittee has requested a response to the following questions:

1. LAO, Please present your findings.

2. DHCS, What can be accomplished in the budget year to proceed on this issue?